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UDS-PRO® PRE-ADMISSION ASSESSMENT

Patient Identification

IDENTIFICATION INFORMATION

1. Facility Information
   A. Facility Name

   _____

   _____

   _____

   B. Facility Medicare Provider Number _____

2. Patient Medicare Number _____

3. Patient Medicaid Number _____

4. Patient First Name _____

5A. Patient Last Name _____

5B. Patient Identification Number _____

6. Birth Date _____ MM/DD/YYYY

7. Gender (1 - Male, 2 - Female) _____

8. Race/Ethnicity (Check all that apply)

   American Indian or Alaska Native A. _____
   Asian B. _____
   Black or African American C. _____
   Hispanic or Latino D. _____
   Native Hawaiian or Other Pacific Islander E. _____
   White F. _____

9. Marital Status _____
   (1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced)

10. Zip Code of Patient's Pre-Hospital Residence _____

EVALUATION INFORMATION

12. Assessment Date _____ MM/DD/YYYY

13. Impairment Group _____
    Enter condition requiring admission to rehabilitation and encode according to Appendix A in *The UDS-PRO System (Including the FIM Instrument) Clinical Guide.*

14. Case Mix Group (CMG)
    CMG assignment is performed as part of the UDS-PRO® software process, but it can also be performed manually using look-up tables in the Final Rule.

15. Projected Admission Date _____ MM/DD/YYYY

COMORBID CONDITIONS

16. Comorbid Conditions

Use ICD-9-CM codes to enter up to four medical conditions.

A. _____ B. _____

C. _____ D. _____

Pertinent Lab Results

_____

_____

_____

_____

_____

_____

CASE NOTES

Prognosis: _____

_____

Premorbid Level of Function: _____

Support System: _____

_____

Rehabilitation Potential: _____

Ability to Tolerate Intensity of Care: _____

Anticipated Discharge Plan: _____

Other Information: _____

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FUNCTION MODIFIERS

Complete the following specific functional items prior to scoring the FIM™ instrument:

PRE-ADMISSION

17. Bladder Level of Assistance ☐
    (Score Item 17 using FIM™ Levels 1 - 7.)

18. Bladder Frequency of Accidents ☐
    (Score Item 18 using the scale below.)
    7 - No accidents
    6 - No accidents; uses device such as a catheter
    5 - One accident in the past 7 days
    4 - Two accidents in the past 7 days
    3 - Three accidents in the past 7 days
    2 - Four accidents in the past 7 days
    1 - Five or more accidents in the past 7 days

Enter the lower (more dependent) score from Items 17 and 18 above into Item 27G (Bladder).

PRE-ADMISSION

19. Bowel Level of Assistance ☐
    (Score Item 19 using FIM™ Levels 1 - 7.)

20. Bowel Frequency of Accidents ☐
    (Score Item 20 using the scale below.)
    7 - No accidents
    6 - No accidents; uses device such as an ostomy
    5 - One accident in the past 7 days
    4 - Two accidents in the past 7 days
    3 - Three accidents in the past 7 days
    2 - Four accidents in the past 7 days
    1 - Five or more accidents in the past 7 days

Enter the lower (more dependent) score of Items 19 and 20 in Item 27H (Bowel).

PRE-ADMISSION

21. Tub Transfer ☐

22. Shower Transfer ☐

(Score Items 21 and 22 using FIM™ Levels 1 - 7; use 0 if the activity does not occur. For information on scoring Item 27K (Tub/Shower Transfer), see *The UDS-PRO System (Including the FIM Instrument) Clinical Guide.)*

PRE-ADMISSION

23. Distance Walked ☐

24. Distance Traveled in Wheelchair ☐

(Code items 23 and 24 using: 3 - 150 feet; 2 - 50 to 149 feet; 1 - Less than 50 feet; 0 - activity does not occur)

PRE-ADMISSION

25. Walk ☐

26. Wheelchair ☐

(Score Items 25 and 26 using FIM™ Levels 1 - 7; use 0 if the activity does not occur. For information on scoring 27L (Walk/Wheelchair), see *The UDS-PRO System (Including the FIM Instrument) Clinical Guide.)*

27. FIM™ INSTRUMENT

☐ Mini-FIM™ Assessment

	PRE-ADMISSION	
SELF-CARE		
A. Eating	☐	
B. Grooming	☐	
C. Bathing	☐	
D. Dressing - Upper	☐	
E. Dressing - Lower	☐	
F. Toileting	☐	
SPHINCTER CONTROL		
G. Bladder	☐	
H. Bowel	☐	
TRANSFERS		
I. Bed, Chair, Wheelchair	☐	
J. Toilet	☐	
K. Tub, Shower	☐	
LOCOMOTION		W - Walk C - wheelChair B - Both
L. Walk/Wheelchair	☐	☐
M. Stairs	☐	
COMMUNICATION		A - Auditory V - Visual B - Both
N. Comprehension	☐	☐
O. Expression	☐	☐
SOCIAL COGNITION		V - Vocal N - Nonvocal B - Both
P. Social Interaction	☐	
Q. Problem Solving	☐	
R. Memory	☐	

FIM™ LEVELS

No Helper
- 7 Complete Independence (Timely, Safely)
- 6 Modified Independence (Device)

Helper - Modified Dependence
- 5 Supervision (Subject = 100%)
- 4 Minimal Assistance (Subject = 75% or more)
- 3 Moderate Assistance (Subject = 50% or more)

Helper - Complete Dependence
- 2 Maximal Assistance (Subject = 25% or more)
- 1 Total Assistance (Subject less than 25%)
- 0 Activity does not occur; Use this code only at admission

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MEDICAL INFORMATION

History leading to admission: _____

Projected rehabilitation IGC (Identify only one): _____

Primary rehabilitation (etiologic) diagnosis: _____

Date of onset: _____ Date of surgery: _____

PAST MEDICAL HISTORY AND PAST SURGICAL HISTORY

CURRENT VITAL SIGNS

HR:_____ BP:_____ RESP:_____ TEMP:_____ HT:_____ WT:_____ O2 SAT:_____ O2:_____ L _____%

COMPLETED LABORATORY REPORTS

Date of report	Results

Does the patient require additional tests prior to rehabilitation admission? ☐ Yes ☐ No

If yes, specify: _____

COMPLETED LABORATORY REPORTS

Date of study	Results

Does the patient require additional studies prior to rehabilitation admission? ☐ Yes ☐ No

If yes, specify: _____

CURRENT COMORBIDITIES (Complete just prior to admission to rehabilitation unit. Check all that apply, and then indicate the intervention required and the risk for complication on the next page.)

☐ Alzheimer's	☐ CHF	☐ Gout	☐ Paresis _____	☐ Sleep apnea
☐ Amputation	☐ COPD	☐ Hypertension	☐ Parkinsonism	☐ Stroke
☐ Anemia	☐ Depression	☐ Hypotension	☐ PVD	☐ SCI
☐ Anxiety	☐ Diabetes	☐ Hypothyroidism	☐ Polyneuropathy	☐ Tracheostomy
☐ Aphasia	☐ Dialysis (hemo/peritoneal)	☐ Malnutrition	☐ Post-polio syndrome	☐ TBI
☐ Asthma	☐ DVT	☐ Morbid obesity (BMI:_____)	☐ Pulmonary embolism	☐ UTI
☐ Atrial fibrillation	☐ Dysphagia	☐ Myocardial infarct	☐ Renal failure	☐ VRE/MRSA
☐ Cellulitis	☐ Encephalopathy	☐ Osteoarthritis	☐ Rheumatoid arthritis	☐ _____
☐ Clostridium difficile	☐ Gangrene	☐ Osteoporosis	☐ Seizure disorder	☐ _____

Additional comments: _____

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SPECIAL NEEDS OR PRECAUTIONS (Check all that apply. Indicate intervention required and risk for complication in the next section.)

- ☐ Allergies: _____
- ☐ Substance use (check all that apply):
  - ☐ Tobacco (amount: _____)
  - ☐ Alcohol (amount: _____)
  - ☐ _____
- ☐ Cardiac Precautions
- ☐ Isolation precautions
  - ☐ Contact
  - ☐ Droplet
  - ☐ Respiratory
  - ☐ Protective
- ☐ Total hip precautions
- ☐ Weight-bearing status
  - ☐ WBAT _____
  - ☐ PWB _____
  - ☐ TTWB _____
  - ☐ NWB _____
- ☐ Splints/braces (specify: _____)
  - ☐ Wearing schedule: _____
- ☐ Safety concerns/precautions
  - ☐ Fall history/high risk for falls
  - ☐ Balance
  - ☐ Cognition
  - ☐ Bed alarm
  - ☐ Chair alarm
  - ☐ Safety enclosure bed
  - ☐ Sitter (hours/day: _____)
  - ☐ _____
- ☐ Complex wound care
  _____
- ☐ Pain Management
  _____
- ☐ IV
  - ☐ Peripheral
  - ☐ Central
  - ☐ PICC
  - ☐ Drip
- ☐ Requires oxygen: _____ liters
- ☐ Bladder incontinence
- ☐ Bowel incontinence
- ☐ Diet consistency
  - ☐ Tube feedings
  - ☐ Dysphagia
  - ☐ Modified consistency _____
- ☐ Hard of hearing
- ☐ Blind
- ☐ Visually impaired
- ☐ Language pref. (other than English)
  _____
- ☐ Interpreter needed
- ☐ Cultural considerations
- ☐ Modified schedule
  - ☐ Requires rest breaks
  - ☐ Dialysis (schedule:_____)
  - ☐ _____
- ☐ Special equipment
  _____

CURRENT CONDITIONS REQUIRING INPATIENT REHABILITATION

Medical/Functional Conditions: Indicate all current medical/functional conditions that require frequent, direct, ongoing, medically necessary direction from a rehabilitation physician to ensure the patient's safe return to the community.

Medical/Functional Condition	Interventions Required	Risk for Medical/Clinical Complications

ANTICIPATED POST-DISCHARGE DESTINATION/TREATMENT

Community Setting
- ☐ Home (check one)
  - ☐ Alone
  - ☐ With supervision
  - ☐ With assistance
- ☐ Board and care
- ☐ Assisted living
- ☐ Transitional living

Institutional Living
- ☐ Intermediate care
- ☐ Skilled nursing facility
- ☐ Chronic hospital
- ☐ Alternate level of care unit
- ☐ Subacute unit

Other Setting
- ☐ _____

Has the patient's discharge plan been discussed with the primary caregiver? ☐ Yes ☐ No

If yes, is the caregiver in agreement with the plan? ☐ Yes ☐ No

Primary caregiver:_____

Phone number: _____

Anticipated home health services: ☐ OT ☐ PT ☐ SLP ☐ Nursing ☐ Social work ☐ Aide

Previously used HH service/provider: _____

Anticipated DME needs: ☐ Ramp ☐ Hospital bed ☐ Commode ☐ WC ☐ Walker ☐ Life line ☐ Oxygen
☐ _____

Outpatient services: ☐ OT ☐ PT ☐ SLP ☐ Dialysis (previous provider/location: _____)

Others (specify): _____

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PREVIOUS HOME EQUIPEMENT (Check all that apply.)

- ☐ Commode
- ☐ Shower chair
- ☐ Tub bench
- ☐ Sock aide
- ☐ Long-handled shoehorn
- ☐ Long-handled sponge
- ☐ Reacher
- ☐ Grab bar(s)
- ☐ Oxygen
- ☐ Ankle-foot orthoses R/L
- ☐ Single-point cane
- ☐ Wheelchair (type: _____)
- ☐ WC cushion (type: _____)
- ☐ Crutches
- ☐ Front-wheeled walker
- ☐ Standard walker
- ☐ _____
- ☐ _____

REHABILITATION GOALS AND PLAN

Patient/family/caregiver goals:_____

Anticipated date of rehabilitation admission:_____ Expected length of stay: _____

Patient/family oriented and agreeable to IRF level of care/facility/plan: ☐ Yes ☐ No

Comments: _____

_____

Reviewer's signature: _____ Assessment date/time: _____

RECOMMENDED LEVEL OF CARE

Inpatient rehabilitation? Yes No

If patient is not accepted for admission to IRF at this time, indicate the reason below:

- ☐ No need for inpatient rehabilitation (no medical necessity or functional level too high)
- ☐ Not suitable for inpatient rehabilitation (medically complex, functional level too low, unmotivated, or unlikely to return to community)
- ☐ Inadequate discharge plan
- ☐ Refusal by patient or family (chose another facility or post-acute venue)
- ☐ Not approved by insurance carrier
- ☐ Rehabilitation bed unavailable
- ☐ _____

If patient is not accepted for admission to IRF at this time, indicate recommended level of care below:

- ☐ Skilled nursing facility
- ☐ Board and care
- ☐ Subacute rehabilitation
- ☐ Assisted living facility
- ☐ Home care
- ☐ _____

UPDATED PRE-SCREEN ASSESSMENT (if patient is not admitted within 48 hours of initial pre-screen)

Medical status/changes: _____

_____

_____

_____

_____

_____

Functional status/changes: _____

_____

_____

_____

_____

_____

Reviewer's signature: _____ Assessment Date:_____ Time: _____

Physician's review and admission determination: _____

_____

_____

_____

_____

_____

_____

_____

Physician's signature: _____ Assessment Date:_____ Time: _____